

**Building and Strengthening Capacity to Promote and Maintain High Quality
Care For Medicaid Beneficiaries
The North Carolina Division of Medical Assistance Asthma Learning
Collaborative
End of Project Report
July 1, 2000 – June 30, 2002**

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This report will describe the implementation and results of the project, *the North Carolina Division of Medical Assistance Asthma Learning Collaborative*, that was a program of the developing partnership between the University of North Carolina Children's Primary Care Research Group (CPCRG)/National Initiative for Children's Healthcare Quality (NICHQ) and the North Carolina Division of Medical Assistance (DMA). This program intends to develop, measure, promote and disseminate positive changes to improve care in primary care practices that serve Medicaid recipients. The asthma learning collaborative established the mechanism for this partnership to build an infrastructure to improve care for all children in the Carolina ACCESS program, and particularly to involve Carolina ACCESS I primary care practices. This report will discuss the NC-DMA asthma learning collaborative, realizing that the same methodology could be used for any other disease specific or preventive condition.

NC IMPROVEMENT COLLABORATORS: NC DMA, CPCRG AND NICHQ

NC DMA Carolina ACCESS Program

In April 1991, the North Carolina Division of Medical Assistance implemented the Carolina ACCESS program, a Medicaid primary care case management model, characterized by a primary care physician gatekeeper. Carolina ACCESS served as the foundation for the managed care program for Medicaid in the state. By linking each eligible recipient with a primary care provider who has agreed to provide or arrange for healthcare services for each enrollee, Carolina ACCESS brings a system of coordinated care to the Medicaid program. By improving access to primary care and encouraging a stable doctor-patient relationship, the program helps to promote continuity of care, while reducing inappropriate utilization and controlling costs.

The Balanced Budget Act of 1997 requires all state Medicaid agencies to develop and implement a quality assessment and performance strategy to improve care provided to Medicaid beneficiaries. Subsequently, the North Carolina DMA undertook several creative quality improvement initiatives for Medicaid recipients while increasing access and containing costs. We will briefly discuss those initiatives that influence the partnership between the DMA and CPCRG/NICHQ and the asthma intervention discussed in this report.

In an effort to impact both the quality and cost of healthcare, the ACCESS II and III programs were initiated in July 1998 to enhance the Carolina ACCESS model by working more closely with local groups of providers and networks. ACCESS II, comprised of local networks of Medicaid providers and one statewide network (ACCESS Care) of large Carolina ACCESS practices, agreed to work together to develop care management systems and supports to optimally manage enrollee care. ACCESS III involves two countywide plan community partnerships involving physicians, hospitals, health departments, departments of social services, and other community providers.

This project is targeted for Access I providers in urban and rural communities across North Carolina. This group has not had as many opportunities to participate in quality improvement initiatives.

The Children's Primary Care Research Group (CPCRG)

The Children's Primary Care Research Group at the University of North Carolina was formed in 1993 to improve the health and development of children and adolescents by increasing the focus on outcomes, effectiveness and accountability at every level of pediatric practice: patient care, practice management, child health policy, and medical education. The CPCRG's vision is to work in partnership with physicians, communities and health systems to develop, test and disseminate strategies designed to improve the clinical effectiveness of health care for children and adolescents. A major emphasis is on linking clinical and public health efforts to improve the health of children and youths. A premise of the research group's philosophy is that better health will result from an integration of individual and population-based approaches.

In 1999, the CPCRG collaborated with colleagues doing similar work in Boston, Vermont, and Seattle to create the National Initiative for Children's Healthcare Quality. CPCRG works closely with NICHQ to develop and implement programs to improve the healthcare that children receive.

The National Initiative for Children's Healthcare Quality (NICHQ)

NICHQ's mission is to reduce the gap between what is and what can be in health care for all children. The strategies NICHQ uses to fulfill this mission include developing new knowledge about improving care and assisting the health care delivery system to put new knowledge broadly into practice. NICHQ brings together the resources of the Institute for Healthcare Improvement, the American Academy of Pediatrics (AAP), and national leaders in clinical and systems improvement. A major focus of NICHQ is on improving the delivery of clinical services and care for children, with extensive experience at both the practice and community level.

NICHQ is a program of the Institute for Healthcare Improvement (IHI), a non-profit organization dedicated to helping health care systems achieve improved health status, better clinical outcomes, lower costs, broadened access, greater ease of use, and higher satisfaction for individuals and their communities. Dr. Donald Berwick serves as the Chief Executive Officer of IHI.

NC IMPROVEMENT PROJECTS

The Challenge of Asthma for North Carolina's Children

An estimated 4.8 million children – 1 in 15 under 18 years of age have asthma in the United States and asthma is a significant health problem for children and families served by Medicaid in North Carolina. In 2000, 28% of children in North Carolina in grades 7-8 reported symptoms of asthma yet only 11% of children in grades 7-8 were diagnosed with asthma. After chronic sinusitis, asthma is the most common cause of chronic illness in children. The asthma rate is rising more rapidly in preschool aged children than in any other group, increasing 160% in the past 15 years in children under 5 years of age. The asthma death rate for children aged 5 to 14 and young adults aged 15-24 years doubled from 1979-80 to 1993-95, and almost three hundred children now die each year from asthma; 150,000 are hospitalized. Although accepted guidelines exist for the care of children with asthma, there is considerable evidence that current practice falls short, resulting in unnecessarily poor health status for children and over-use or inappropriate use of health care resources.

The North Carolina Statewide Asthma Improvement Project

Given the large burden of pediatric asthma and the documented opportunities for improvement in asthma care, CPRG/NICHO received funding from the Packard Foundation, beginning in July 1999, to improve health care for children. One of the initiatives supported by these Packard funds, the North Carolina Statewide Asthma Improvement Project, is designed to improve the health of children with asthma in North Carolina through a series of tiered interventions. In 1999, a group of key stakeholders, the Partnership for Asthma Improvement and Resources, was formed to publicize the opportunities to improve asthma care. This group is closely aligned with the state health department's NC Asthma Task Force, headed by Dr. Jerry Wiley. Broad educational strategies were targeted to all 1457 practices in North Carolina that care for children on Medicaid. More intensive strategies involve a smaller group of practices to illustrate the potential benefits of assistance in putting evidence-based approaches into practice. The strategies include:

1. Publicizing the opportunity to improve asthma outcomes. During its first year, the Initiative worked with the NC Medical Society, the NC Pediatric Society and Education Centers (AHECs) and academic medical centers to provide information about the barriers to better asthma care and the potential gains that can and have been made.
2. Sharing ideas about how to improve asthma care. Targeting all 1457 practices in North Carolina that care for children on Medicaid, this intervention developed a three-hour interactive CME program to increase knowledge about asthma care as well as strategies to improve care. Approximately 600 physicians have participated in the 10 scheduled sessions. Participants fill out a questionnaire prior to the session about their current asthma care practices. Baseline data collection is complete, and revealed a range of opportunities for significant improvement. Only 11% of

physicians reported that they almost always provide a written asthma management plan; this suggests that there is a significant opportunity to improve care for children with asthma in 89% of physician practices. Fully 70% reported that their practice does not use a system to recall patients with asthma for flu vaccination.

Although an educational session can share knowledge about improving care, multiple reviews of practice change strategies confirm that the passive provision of information rarely achieves its intended goal of improving practice performance (Davis, 1995; Davis, 1999). Knowledge is necessary but not sufficient to produce behavior change. Multi-faceted interventions targeting different barriers to change are more likely to be effective than single interventions. In particular, activities that appear to have a positive effect include those with active learning opportunities, learning delivered in a longitudinal or sequenced manner, and the provision of methods to facilitate implementation in the practice setting. (Davis, 1999). The learning collaborative approach, described in the following paragraphs, combines many of these successful strategies.

3. Practice-based assistance via Asthma Learning Collaboratives. This third component, an Asthma Learning Collaborative, was provided for Carolina Access I practices, with monies from federal matching funds. We focused on Carolina Access I practices as, unlike Access II and III sites, no coordinated disease management focus has been implemented in the Access I practices.

An Asthma Learning Collaborative is based on principles of continuous quality improvement and built on the experience and methods of the Institute for Healthcare Improvement's "Breakthrough Series" (BTS). As described below, this approach had already been refined and implemented in a successful Asthma Learning Collaborative involving 23 practices in the AccessCare Medicaid network in North Carolina.

ACCESS Care Asthma Learning Collaborative 1999

In 1999 CPRG/NICHO worked with ACCESS Care, a Carolina Access II Medicaid managed care network in North Carolina, to improve the quality of care for pediatric patients with asthma. An asthma learning collaborative with 23 pediatric practices with formed. Over 80,000 children are enrolled in the AccessCare network sites involved in this Learning Collaborative.

A BTS brings together health care providers who share a commitment to making major, rapid changes, producing improved healthcare processes and better health outcomes. Sound science exists to guide the efforts to improve current practices, but much of this science lies unused in daily work. A Collaborative is designed to close the gap between what is known in the literature and current practice.

By bringing together participants from different practices, along with experts in the clinical topic and quality improvement techniques, a Collaborative provides an effective

setting for practitioners to study scientific evidence, learn how to put that knowledge into practice, and make lasting improvements in their own practice patterns.

The ACCESS Care practice teams participating in the Asthma Learning Collaborative were not volunteers, but were required by network administration to take part. Previously, these practices had had no experience with office-based quality improvement and measurement methods. This project made substantial progress over the first nine-months in the care of asthma patients improving the documentation of asthma severity from 39 to 74 percent and increasing written management plans from 65 to 68 percent.

HCFA-sponsored Breakthrough Series 2000: NC DMA Asthma Collaborative for ACCESS I practice

In August 2000, North Carolina DMA was invited to participate in a HCFA-SAMSHA sponsored Breakthrough Series (BTS) offered by the IHI in order to improve care provided to Medicaid beneficiaries with asthma (and depression). This collaborative focused on making changes that support care improvement either at the direct care level or at the MCO level. Since many of the state's Medicaid providers were involved in a coordinated quality improvement program by virtue of being a participant in the Carolina ACCESS II and III project, the remaining practices, referred to as Carolina ACCESS I, became the direct care provider population for North Carolina. The targeted outcome for the HCFA-sponsored BTS was for Medicaid agencies to improve their working relationship with direct care providers and develop an expertise in the application of quality improvement methods for internal and external issues. The long-term goal was to work towards creating a sustainable infrastructure that could support improvements and deepen the understanding among DMA and practices about how to accelerate the process of making and sustaining improvements in the care Medicaid beneficiaries receive.

In its response to HCFA, NC DMA set the following objectives for this effort:

- Asthma management is a challenging undertaking, both for healthcare providers and individuals that live with the disease on a daily basis. It is also costly, in terms of healthcare dollars spent, and the effects on quality of life. To address these concerns, the North Carolina Division of Medical Assistance, Department of Managed Care, will partner with the UNC Children's Primary Care research Group/National Initiative for Children's Healthcare Quality to provide opportunities to improve asthma care management in the Primary Care Provider setting.
- Building on a successful initiative recently completed with Carolina ACCESS II/III primary care providers, twenty Carolina ACCESS primary care providers will be recruited to participate in an asthma learning collaborative based on principles of continuous quality improvement and built on the methods of IHI's "Breakthrough Series".

- Project goals for each provider include:
 - Increase the proportion of pediatric asthma patients assigned a severity level on their medical record to 90%;
 - Increase treatment with maintenance anti-inflammatory medication in pediatric enrollees with persistent asthma to 100%;
 - Increase the proportion of asthma patients who receive a written asthma management plan to 90%;
 - Increase symptom-free days to 90% (ie-a patient is symptom free for 90% of the days in a 14 day period);
 - Decrease ED visits for asthma to <1% of the asthma population
 - Decrease hospital admissions for asthma to <2% of the asthma population
- Providers who agree to participate in the collaborative will develop practice teams including at least one physician and one other practice member. The practice teams will attend learning sessions to hear about new approaches in asthma care, and receive coaching on changing their office systems. Practice tools will be provided, and participants will receive comparative data about their practices to guide improvement activities. All pediatric enrollees with a diagnosis of asthma (per HEDIS guidelines) served by the participating practices will be included in the project population.
- Factors such as the variety of practice settings and lack of concentrated disease management efforts in Carolina ACCESS practices, and the challenges of initiating this project close to the approaching holiday and winter season will delay our initial data collection and process implementation efforts. However, by ensuring that we recruit providers that are committed to learning and implementing best practices in asthma care management, it is anticipated that the ambitious goals set for this project will be achieved.

For participation in this HCFA BTS, the North Carolina DMA proposed an asthma learning collaborative for the Carolina ACCESS I sites since these practices had had no previous organized disease management or support for quality improvement initiatives. To undertake these ACCESS I efforts, DMA asked the CPCRG/NICHQ to develop an asthma learning collaborative for primary care practices in the Access I sites. Because ACCESS Care had participated in the 1999 ALC, the DMA was familiar with this quality improvement approach and the tools for the learning collaborative were already developed. Using this approach for the Access I sites spreads a consistent method of improvement for asthma patients across these practices.

THE COLLABORATION BETWEEN CPCRG/NICHQ AND DMA: BUILDING AND STRENGTHENING CAPACITY TO PROMOTE AND MAINTAIN HIGH QUALITY CARE FOR MEDICAID BENEFICIARIES

Objectives

1. Develop a working partnership between the DMA and CPCRG/NICHQ to enable DMA to accelerate improvement in primary care practices caring for Medicaid recipients. Through this partnership DMA will expand their capacity to develop, measure, promote and disseminate positive changes that can improve care.
2. Improve the care of children with asthma in 20 Carolina Access I practices through the establishment of an asthma learning collaborative to begin in Spring 2000.

Develop partnership for improvement between DMA and NICHQ. In addition to the statewide asthma educational effort and learning collaborative, an additional objective for these matching funds is to accelerate improvement and build on work already begun with the Carolina Access II and III programs.

Working together, DMA and CPCRG/NICHQ began to develop the infrastructure necessary to sustain improvement efforts found to be efficacious and feasible beyond the completion of the project. Throughout the project, CPCRG/NICHQ personnel worked with DMA staff to determine optimal strategies to build capacity for improvement within DMA. A Steering Committee consisting of DMA staff and CPCRG/NICHQ faculty reviewed learning collaborative activities and progress on a regular basis; in addition, they discussed and identified needs for additional improvement efforts in primary care practices (e.g., ADHD, Open Access).

The remainder of this document will summarize the design, implementation and results of the NC.DMA.ALC. (See Appendix A: Learning Collaborative model)

Recruitment Strategies

DMA initially suggested a pilot improvement project involving 5-7 ACCESS I practices. We suggested beginning with a larger group of practices for two reasons: 1) team learning is enhanced with a larger pool of collaborators; and 2) we considered there might be variable participation and some attrition due to the sustained length of the collaborative effort. We proposed involving 20 ACCESS practices that cared for children.

Targeting Practices for Recruitment

In order to impact the largest number of children with asthma, we reviewed aggregate Medicaid asthma claims data and set several parameters for recruitment:

- An Access I pediatric practice
- The practice has a high volume of children with asthma

- The practice has a large number of children on Medicaid

Of the ACCESS I practices meeting these parameters, 35 primary care practices were identified. All 35 sites were sent an information packet about the ALC and then received a follow-up call by either Drs. Carole Lannon, Peter Margolis or Dave Goff or one of two physicians who participated in the previously described Access II ALC.

Following these phone interactions, a total of 25 sites verbally agreed to participate. Several sites that agreed to participate did not have a large volume of children on Medicaid but they had previously participated with CPCRG in other improvement projects and they could benefit from participating in this collaborative. These sites then received a packet of information to complete information about their practice and to sign a letter of agreement. After this step, 17 sites signed the letter of agreement and completed the packet. (See appendix B: Table-All Recruited and B2 Table-Practice Status during Collaborative). These sites serve over 35,000 children as Medicaid enrollees.

The practices participating in the ALC were not required to participate. However, the designated practice were expected to commit their time to the various learning sessions, conference calls and quality improvement activities required for the ALC.

Data Management

This section describes the ongoing data collection process involved in a BTS to measure whether practices are achieving their expected outcomes.

Data Collection: There are two parts to the data collection in this Collaborative: baseline and ongoing. Baseline data is essential to inform the participating practices about current asthma care in their practice before beginning an improvement project. The ongoing data collection helps track the progress of the participating practices over the time of the learning collaborative and refine their improvement plans.

The goal for baseline data collection is to obtain data on visits for 20 consecutive patients with a previously established diagnosis of asthma, who are at least one but not more than 18 years old prior to the first Learning Session. The data comes from two instruments, *Living with Asthma Survey* and *Asthma Chart Review Form*. These two instruments should be completed on the same patient.

Following the first Learning Session, data collection continues in order to track improvements from practices both individually and collectively. The goal of the ongoing data collection is to collect data from the above two forms on a minimum of three patients with asthma each week – either maintenance or acute asthma visits. The Data Coordinating Center at the CPCRG uses these data to provide monthly reports for each practice.

All forms are sent to the Data Coordinating Center at CPCRG via fax.

Patient Confidentiality: In order to ensure client confidentiality, all practices are asked to complete a log of asthma visits and to assign a unique ID code number for each client. This code number is placed on both instruments for the same client. The instruments do not identify a client by name.

Instruments

The following instruments were used to evaluate improvements in asthma care at primary care practices and an assessment of asthma learning collaborative.

Instruments to evaluate improvements in asthma care at primary care practices:

Living with Asthma Survey

The first page of the survey is to be completed by the patient or parent before the visit to facilitate the provider's assessment of asthma symptoms and severity. The second page should be completed by patient or parent after the visit to help assess asthma management at that visit. (See Appendix C: Living with Asthma survey)

It is believed that the survey will: save time with the medical visit because the health care provider can quickly review the patient's responses on the survey; the survey covers aspects of the patient's health status that are important to evaluating severity according to established professional guidelines; the survey may prompt the patients to think about asthma related issues that they might not recognize as obviously important; and the survey is designed to make asthma classification of severity simpler for clinicians.

Chart Review

Providers fill out a chart review instrument on all patients with a completed asthma survey. The purpose of this instrument is to identify documentation of: the type of visit; severity of the asthma; medications prescribed at this visit; frequency and route of beta2-agonist, if prescribed; and whether or not an asthma management plan was created, reviewed, or updated at this visit and whether the family received a copy of the plan. (See Appendix D: Chart Review form)

Assessment of Chronic Illness Care

All participating practices were asked to complete the *Assessment of Chronic Illness Care* instrument prior to attending the second Learning Session. This instrument was developed to help organizational teams identify how well they are providing care for chronic illness in six areas: organization of health care; linkages to the community; self-management support; decision support; delivery system redesign; and clinical information systems. These six areas correspond to the Chronic Care Model developed by Dr. Ed Wagner, a model for effective chronic illness care based on a survey of best practices, expert opinion, promising interventions in the literature and quality improvement work. These components are the basis for the collaborative curriculum. (See Appendix E: Assessment of Chronic Illness Care survey)

Monthly Progress Reports

Each practice completes a monthly report identifying changes that were tested and/or implemented and the results from those changes. The project director reviewed to understand specific changes for each team and to assess team's understanding of improvement methods (small tests or cycles). These changes are then identified on the monthly data reports to determine if the process and outcome measures improve as a result of making these changes. (See Appendix F: Monthly Progress Report template)

Project Director's Monthly Report

Each month the project director writes a report on the status of the learning collaborative. The report identifies the number of participating teams; the aims of the ALC; monthly data measures for the collaborative; issues that were addressed during the month; and aggregated data that assesses how teams were rated by the director, the mean team rating for that month; number of teams that submitted a monthly report; number of teams that submitted data that month; and percent of teams that were rated a 4 or above on a 5 point Likert scale. The purpose of this report is to assess collaborative progress. This is discussed with the Improvement Advisor on a monthly basis. Strategies are developed to address trends and problem areas.

Instruments to evaluate the Asthma Learning Collaborative:

The following instruments describe the various tools that were used to evaluate the components of the ALC.

Evaluation of each Learning Session

Each learning session was evaluated by participants to determine if the stated objectives were achieved, if the topic discussed was pertinent to stated objectives, if the purposes and goals of the session were met, and if appropriate teaching strategies were used. All physician and nurse attendees had the opportunity to earn CME and CEU credits for attending these learning sessions. (See Appendix G: Learning Session I, II and III Evaluation forms)

Evaluation of the ALC

All participants in the ALC were asked to complete a short evaluation instrument about their experience with the ALC. All questions used a five point Likert scale with space for additional comments. The instrument asked questions about whether the expectations and experiences during all phases of the ALC with several open-ended questions asking for feedback about the structure, process and content of the Learning Sessions. (See Appendix H: ALC Evaluation form)

Conference Call Survey

A survey instrument was designed to assess the participant's perception of the various conference calls. The instrument was sent to all active participants. (See Appendix I: Conference Call survey)

Results

This section describes the actual sequence of learning session activities staged throughout the ALC, and the results from the evaluation of the improvements in asthma care at primary care practices and of the asthma learning collaborative itself.

As previously described, the ALC is a series of three learning sessions on key topics in the management of care for pediatric clients with asthma. In between each learning session is a series of short conference calls reinforcing material covered in the learning session and offering participating practices the opportunity to discuss successes they have had in implementing new strategies and problems they have faced. The various practices can problem solve with other practices experiencing challenging situations and can learn from their peers strategies that might be successful in their practice. It is also an opportunity to discuss the results of their data and the trends demonstrated by the data.

The following table summarizes the major activities of the asthma BTS, including the topics covered in the three learning sessions, dates of the learning sessions, number of participating sites in each session, and the conference call topics covered in each of the three action periods. (See Appendix J: Table of Participation)

ALC Learning Sessions and Conference Calls

Topics Covered	Date	# Sites Participated	# Collaborative Team Members Participate
Learning Session 1 (LS1)	3/28/01	16	32
<ul style="list-style-type: none"> Defining the gap Improving Chronic Illness Care Model Core Components of Asthma Care Baseline Assessment Model for Improvement Self Management Support Measurement and QI Using a Registry Delivery System Design 			
Action Period I: Topic Specific Conference Calls	3/28/01-5/31/01		
<ul style="list-style-type: none"> Diagnosis & Severity 	4/11/01	5	6
<ul style="list-style-type: none"> Data Collection 	4/25/01	7	10
<ul style="list-style-type: none"> Management Plans 	5/9/01	6	8
<ul style="list-style-type: none"> Dr. David Peden 	5/23/01	8	13
Learning Session II (LS2)	6/6/01	12	15
<ul style="list-style-type: none"> Examples of Successful Changes Self Management Support Spreading Change Team Sharing of Changes What happens when they don't get better Decision support – Clinical update Community Resources Smoking Cessation 			
Action Period II: Topic Specific Conference Calls & Check-In			
<ul style="list-style-type: none"> Registry 	6/27/01	3	3
<ul style="list-style-type: none"> Check-in 	7/11/01	7	12
<ul style="list-style-type: none"> Back-to School 	7/25/01	2	2
<ul style="list-style-type: none"> NICHQ Registry 	8/7/01	2	2
<ul style="list-style-type: none"> Drugs 	8/22/01	2	2
<ul style="list-style-type: none"> Check-in 	9/5/01	4	6
<ul style="list-style-type: none"> Flu season 	9/19/01	3	3
<ul style="list-style-type: none"> Environmental Health 	10/10/01	1	1
<ul style="list-style-type: none"> Check-in 	10/24/01	2	2
Learning Session III (LS3)	11/15/01	6	6
<ul style="list-style-type: none"> Team sharing Culture and clinical care Delivery system design Progress to date Asthma management in the school setting Managing chronic illness – building the business case 			

As you can see from this table, not all of the seventeen sites actively participated throughout the ACL. Because of some of the challenges faced by the practices such as unexpected illnesses and resignations, the clinical demands of pediatric practices, and the additional requirements for participation in the ALC necessitated that three sites

withdraw from active participation after the second learning collaborative. Several other sites had limited participation in the ALC because of internal challenges but they remained active participants of the collaborative.

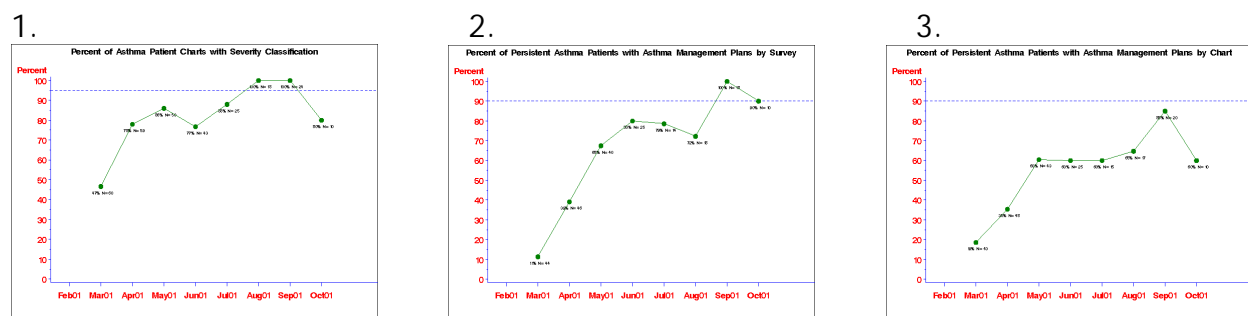
Results from Process and Outcome Improvement Measures

The next section indicates the results from the three process and nine outcome measures tracked throughout the collaborative. These data are aggregated across all the sites. The limited number of participating sites and clients does not allow us to disaggregate these data and draw any reliable conclusions. In addition, these data need to be interpreted with the understanding that not all sites sent in data and the sites that did were more likely to be doing well with other aspects of the Learning Collaborative; in other words, these practices may have had the internal infrastructure to do well.

The following data are from the Living with Asthma Survey (patient/parent perspective) and the Chart Review. Some of the same measures are found in both the patient instrument and chart, e.g. which medications are prescribed, whether an asthma management plan is available. Only data from maintenance (115 records), follow-up (137 records) and well child visits (70 records) are used in the following run charts. Data from acute care visits (189 records) are not used in the evaluation of the process measures, as it is difficult to accurately interpret the appropriateness of severity and treatment.

This first section describes the results from the three process measures. First you will see the run-charts from the three process measures followed by a table describing the individual measures and a brief explanation of the trend seen.

Process Measures



These run charts reflect the three process indicators used to measure the implementation of improvement strategies within the primary care practices: percent of asthma clients with a severity classification as documented in the chart review; percent of asthma patients with an asthma management plan as reported in the parent survey; and percent of asthma patients with an asthma management plan as documented in the chart review.

The following table describes the findings associated with these three process measures.

Description of Findings Associated with Process Measures

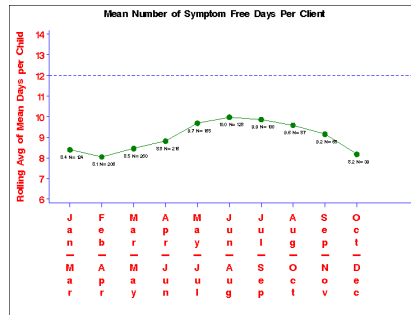
Process Measure	Data Source	Findings
1. % Patient Charts with Severity Classification	Chart Review	Trend shows a rapid increase in percent of patient charts with severity classification between March and May and remained near target for the rest of project
2. % Persistent asthma patients with asthma management plans	Patient/Parent Survey	Chart demonstrates that at baseline almost no patients had an asthma management plan and shortly after the first learning session (March) the majority of patients reported receiving one. Trend stayed consistent for remainder of project
3. % Persistent asthma patients with asthma management plans	Chart Review	Same as above with the exception that the percent of asthma plans documented in the client chart is less than those reported by the patient survey.

The three process measures described all demonstrate that a substantial improvement took place after the first learning session in March 2001 in the documentation of asthma severity and use of asthma management plans. These results indicate that improvements did take place at the practice level for pediatric practices that submitted data.

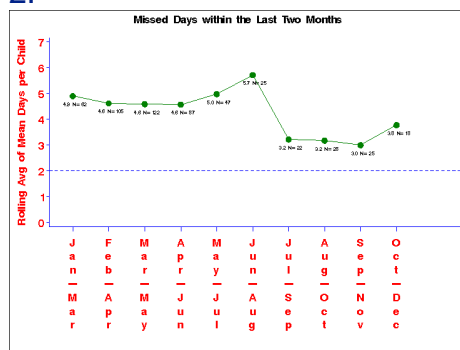
The next section shows the run charts for the nine outcomes used to measure improvements. It is followed by a table explaining the findings for each of the nine measures.

Outcome Measures

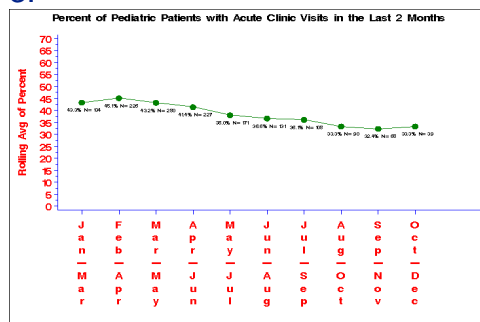
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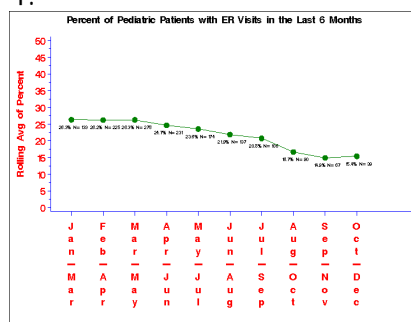
2.



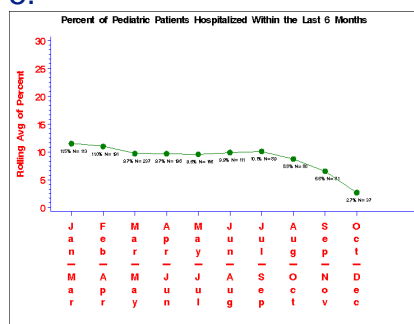
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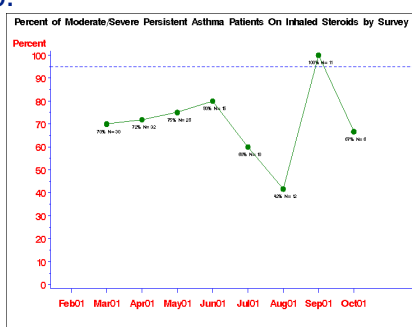
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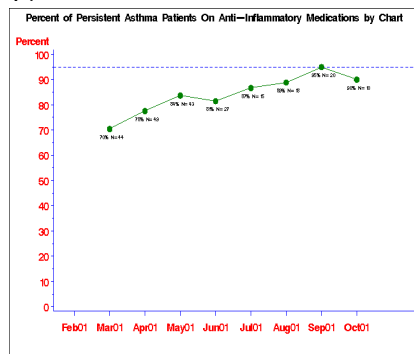
5.



6.



7.



Outcome Measures: The above charts show data for the following: Mean number of symptom free days; missed school days within the last two months; acute clinic visits in the last two months; percent of pediatric patients with ED visits in the last six months; percent of pediatric patients hospitalized in the last six months; percent of moderate and severe asthma patients on inhaled steroids; percent of asthma patients on anti-inflammatory medications.

The interpretation of these nine outcome measures is found in the following table. The table indicates the name of the indicators, which instrument was used for the run chart, and the key findings describing the trend from each measure.

Description of Outcome Measures

Outcome Measure	Data Source	Findings
1. Mean Symptom Free Days	Patient/Parent Survey	Appears that symptom free days improved between March and September. With the limited number of clients between October and January, cannot discern the reason for the reverse trend.
2. Missed school days within last two months	Patient/Parent Survey	Overall trend shows there are less missed school days.
3. % Pediatric patients with acute clinic visits in last 2 months	Patient/Parent Survey	Appears there are fewer acute care visits between March and October.
4. % Pediatric patients with ED visits in last 6 months	Patient/Parent Survey	Appears there are fewer ED visits between March and October.
5. % Pediatric patients hospitalized within last 6 months	Patient/Parent Survey	Appears there are fewer children hospitalized
6. Moderate/severe asthma patients on inhaled steroids	Patient/Parent Survey	Unable to discern if there is change in inhaled steroids with these data
7. % Persistent asthma patients on anti-inflammatory medications	Chart Review s	The chart review data indicate a positive trend in the use of anti-inflammatory medication.

*These data do not include 37% of data from acute visits

Although these results need to be interpreted with caution because of the limited number of sites and small number of asthma patients represented, overall, these measures generally show a very modest positive trend to achieve the intended outcomes.

The trend seems most consistent for increased use of anti-inflammatory medication for patients with persistent asthma and for a reduction in missed school days.

Evaluation of Asthma Learning Collaborative

It has been very important to evaluate not only the process and outcome measures of the ALC but also how well the ALC met the needs of the participating pediatric practices. The following section describes the results from the conference call survey, assessment of the ALC, assessment of the three learning sessions, and telephone interviews with sites, the project director's report and the report issued to sites offering feedback about the practices participation in the ALC.

Improvements and Challenges Identified from ALC Evaluation Instruments

Data Collection Instrument	Improvements Made	Challenges
Progress reports written by project director to participating sites	<ul style="list-style-type: none"> Data indicate that sites are generally moving in the right direction 	<ul style="list-style-type: none"> Insufficient data sent in by sites. Sites not matching patient surveys with chart surveys (less chart surveys) Poor attendance on conference calls Only a few sites using the registry
Conference call survey (5/17 sites completed survey) There were a total of 13 potential conference calls offered to participating sites	<ul style="list-style-type: none"> Appreciated the sharing and encouraging from calls Re-energized from calls Received helpful information about asthma management Learning strategies and the successes and failures of other groups inspires my group Many types of reminders given to sites about conference calls (faxes, email, calls) 	<ul style="list-style-type: none"> 4/5 respondents attended only 1-3 calls Although noon hour suggested as best time to schedule calls, this proved to be a difficult time for teams participate in conference calls because of patient care and practice meetings Call discussions were sometimes repetitive Suggest either shorter duration or less frequent calls
Assessment of the ALC (2/17 sites completed the instrument)	<ul style="list-style-type: none"> Learning sessions, pre-work packet were very helpful and of high quality (on a 5 point Likert scale, session quality was generally rated a 4; where 1 is low and 5 is high) 	<ul style="list-style-type: none"> On a 5 point Likert scale, sites rated the ALC being a good fit for their organization as a 2 (1 is low and 5 is high)
Assessment of the three learning sessions <ul style="list-style-type: none"> Learning Session 1 (3/28/01) Attendance: 47 (MD=14; RN and others=33) Learning Session 2 (6/6/01) Attendance: 23 (MD=6; RN and others = 17) Learning Session 3 (11/16/01) Attendance: 7 (MD=2; RN and others= 5) 	<ul style="list-style-type: none"> On a four-point scale, all three learning sessions were rated between 3.4 and 3.8. Participants felt that the material presented, hand-outs and practical tools were very helpful and applicable to practice setting 	<ul style="list-style-type: none"> Decrease in attendance at last two learning sessions Several participants preferred more discussion time No reason indicated on evaluation for drop in attendance

Data Collection Instrument	Improvements Made	Challenges
<p>Telephone interviews with practices at end of learning session two (See Appendix K: Category I-III practice teams and goals) 5/17 were reached for interviews. Sites were classified according to their level of performance: Category 1: Practices facing unforeseen challenges; Category 2: Practices requiring additional support; Category 3: Practices meeting or exceeding expectations</p>	<p>Category 1: Recommendations</p> <ul style="list-style-type: none"> Staff indicated that they would be willing to participate in another collaborative if expectations clear at beginning Felt more connection to Carolina Access System needed. <p>Category 2: Improvements & Recommendations</p> <ul style="list-style-type: none"> Made changes at practice level bring in asthmatic children for a follow-up appointment every 3-6 months where it was previously every year Technical assistance from CPCRG has been great but some practices feel they have not done their part. <p>Category 3: Improvements & Recommendations</p> <ul style="list-style-type: none"> Grateful for ALC and having to make changes. Now changes are a habit <p>"It's made a world of difference...it's been a long time since an asthmatic patient has been admitted to the hospital ... education is key"</p>	<p>Category 1: Challenges with ALC</p> <ul style="list-style-type: none"> Staff turn-over presented a problem Busy practices had to track other issues like immunization Staff did not see ALC as a priority because they were doing similar care with asthma clients Teams were not identified to participate with ALC Limited use of internet or no access Limited leadership support <p>Category 2: Challenges</p> <ul style="list-style-type: none"> Labor intensive process Conference calls fall during a work meeting they cannot miss Leadership support of one physician only Staff turn-over and illness <p>Category 3: Challenges</p> <ul style="list-style-type: none"> Wednesdays are a particularly busy day for the practices Encourage more focus on community involvement – e.g. sending management plans to schools
<p>Project Director's Report</p>	<ul style="list-style-type: none"> Although practices are not active participants, they report making positive improvements in their practices. Using multiple modes of communication to engage sites in the ALC (faxes, calls, mailings) Six practices trying registry % Teams reaching a 4 (out of 5) was consistent with IHI National Collaboratives and other NICHQ Asthma Collaboratives (20% reached a 4) Sites with a nurse practitioner generally are higher performers and appear to coordinate team functions with ALC if senior leadership is active. 	<ul style="list-style-type: none"> Communications difficult Minimal participation on ALC by sites 4 practices never really became involved Data collection is difficult for most teams (<20 %) – seems to depend on one person in most instances Back to school period stopped or slowed surveys and chart reviews Teams report having problems with the NICHQ registry Average conference call attendance since second learning session is less than 3 sites
<p>Assessment of Chronic Illness Care Form (2/17 sites completed form)</p>		<ul style="list-style-type: none"> Could not analyze data since only two sites completed the form

Summary of Results

These results indicate that participating practices made substantial improvements in providing care to children with asthma. In particular, after the first learning session in March 2001, practices made significant improvements with classifying patients according to their severity and in developing a management plan for their patients and sharing that plan with their clients. Although the outcome measures did not demonstrate the same consistent trends as the process measures demonstrated, nevertheless children appear to have missed less days of school and experience more symptom free days between March and September. Additionally, more children with persistent asthma are taking anti-inflammatory medication. Between March and October when the number of clinics submitting data was the highest, there was a trend to less acute care visits for asthma patients and less emergency department visits. It is difficult to tell from these data if the number of hospitalizations changed.

In the various interviews and surveys with practices, they consistently indicated that the information they received from the learning sessions, conference calls, tool kits and other handouts was excellent. The practices were challenged by the amount of effort, time and coordination needed to attend the various required sessions and the amount of data they needed to submit. This resulted in generally poor attendance at the conference calls, learning sessions and an inadequate amount of data submitted from all participating practices. This was especially true of practices that lacked leadership support for participation in the ALC and practices that had unexpected changes in staffing.

Limitations (Unforeseen barriers and challenges)

- Recruiting was challenging and time-consuming
- More difficult to recruit and retain practices than expected
- Sites may not have a full understanding of what would be expected of them during the Collaborative. This may be due to adaptation of the curriculum as well as the challenges of quality improvement in primary care.

Discussion

The Asthma Learning Collaborative produced many positive tangible and intangible results. From a policy perspective the ALC demonstrated many successes. The Federal and State priority to improve the quality of care for children with chronic diseases as described in the Institute of Medicine Report (2001), *Crossing the Quality Chasm*, translated directly into a program for improving care for children with asthma. Support for this initiative came from both private and public revenue streams. Federal and State of North Carolina policymakers, primary care providers, and national and state improvement experts collaborated to develop a program that addressed the needs of

vulnerable children on Medicaid who have asthma. These public – private partnerships can maximize resources to improve health services for vulnerable children on Medicaid.

The program results demonstrate that the pediatric practices made improvements in how they offered care to children with asthma. More children with asthma and their parents recognized that they had a management plan that they followed. Pediatricians classified the severity of their patients, which they previously had not done systematically. There was a carefully designed plan for each child based on the needs of this child that produced tangible outcomes. This resulted in less children missing school because of asthma thereby lessening their vulnerability to succeed in school because of a chronic illness. It also resulted in reducing visits to the emergency department and acute care visits for asthma. Not only do children benefit by having improved health but it also conserves scarce public resources for health care.

The actual learning collaborative faced several challenges that need to be considered. This was the first time that the learning collaborative model was used for small, often rural, pediatric practices. The participation in learning sessions, frequent conference calls, and a consistent need for data and other types of information require considerable time and commitment of staff. Even the most dedicated physician that wants to offer excellent care may not be able to take on these additional functions without a team approach. They see the need to take care of the immediate needs of their patients as their top priority. Consideration needs to be given to how to adjust the learning collaborative design to meet the needs of the smaller practices.

Another consideration should be given to how to enroll pediatric practices in a Collaborative. Typically with the Institute of Healthcare Improvement model, practices ask to participate and they pay to do so. In the NICHQ model, practices are asked to contribute physician and staff time. We may need to evaluate how to best optimize pediatric practice participation. Should there be a more rigorous application process? During the application process, should practices be required to demonstrate some experience with teams to implement changes in the office? Finding this balance is important. Policy makers want to fulfill their charter to society by offering excellent health care to children as a public good. Providers want to offer excellent health care to children, yet their resources continue to be constrained. Finding this balance is crucial.

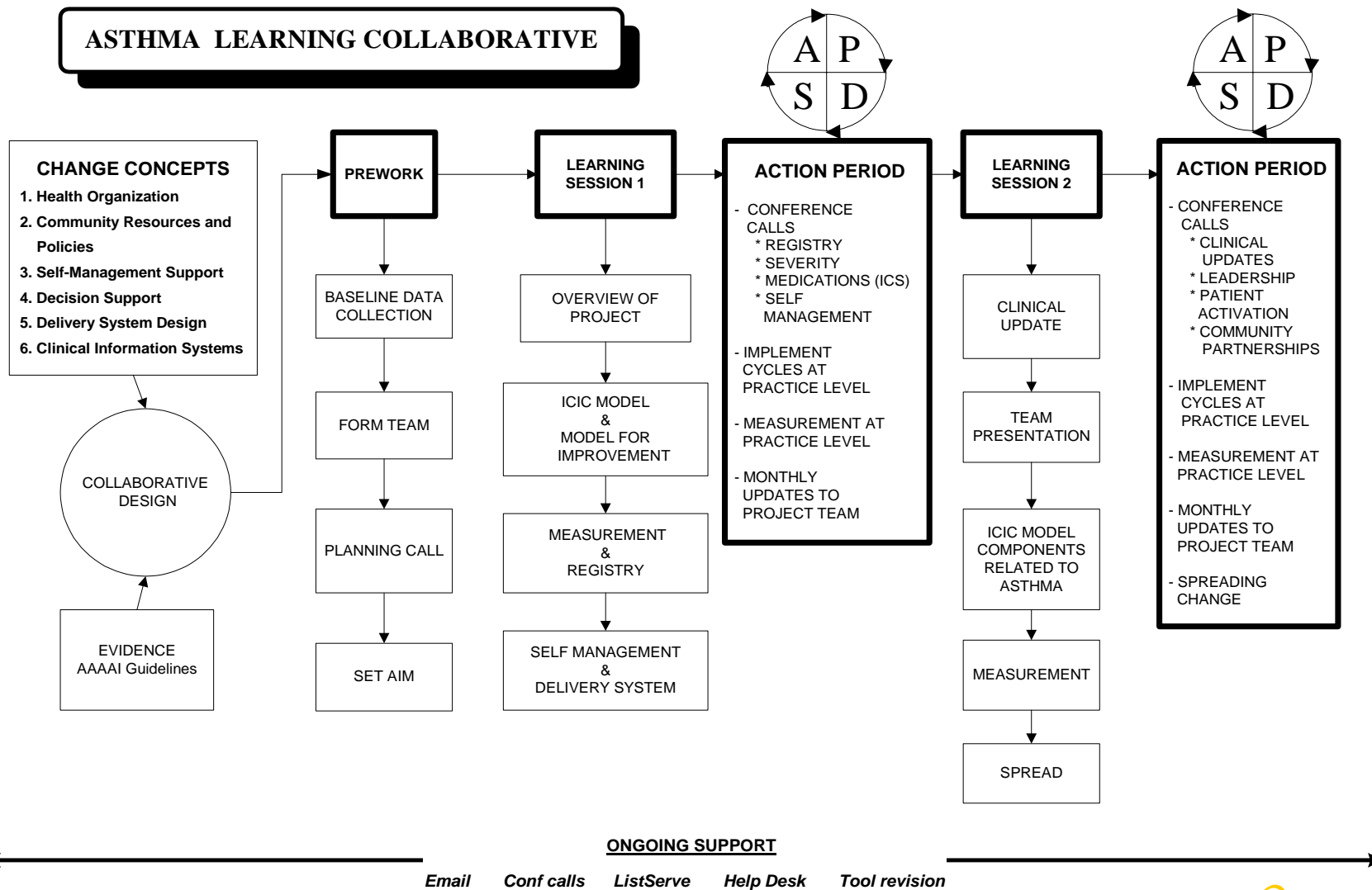
This collaborative reiterated the importance of both leadership and team participation. The teams that seemed most successful had a multi-disciplinary team that actively participated in all phases of the collaborative. Teams that were less successful may have had only one provider that participated or they had non-physician participants but did not have buy-in from key leaders in their organization. Buy-in from leadership was an essential ingredient for success. Leadership valued the collaborative process and gave their “permission” for the rest of the team to participate. On the other hand, practices that had leadership support but no support from other staff did not have a team. Since the collaborative process addresses the needs of the health system within the practice, a team effort is required.

Next Steps

- Build awareness about asthma improvement work, reach more providers, and spread practical tools and effective strategies for improving the care of children with asthma across North Carolina
- Disseminate the work of these practices through presentations at statewide meetings including the NC Asthma Initiative Asthma Summit utilizing physicians from the collaborative to teach others (Drs Lannon and Harris, June 2002)
- Highlight tools (www.nichq.org) and on-line collaborative model (www.eqipp.org)
- Communicate results and community collaborations through professional society mailings (NC Peds Society and NC School Nurse Association June 2002)
- Test method of shortened collaborative using www.eqipp.org with 2002 professional society annual meetings
- Test collaborative method for improving care of children with asthma seen by residents in training using www.eqipp.org
- Explore/work with Betty West DMA program operations coordinator, to highlight upcoming activities as well as websites for tools and on-line learning collaboratives
- Test updated P.A.I.R CME workshop utilizing AAP eQIPP Asthma Module with interactive session. (Ashe Co)
- Collaborate with the NC Asthma Initiative to monitor outcomes for children with asthma statewide.

Our efforts have helped to improve care for children with asthma in North Carolina. In summary, we have learned much through our collaboration with the Division of Medical Assistance. We look forward to incorporating what we have found in our next combined effort.

ASTHMA LEARNING COLLABORATIVE



Site Name	Site Address	Site City	ZIP	County	Telephone	Fax	
ABC PEDIATRICS OF DUNN PA	802 Tilghman Drive	DUNN	28334	Harnett	910.892.1333	910.892.2929	Dr. Brenda Surles
AEGIS FAMILY HEALTH CENTER DBA	167 Moore Road/PO Box 2468	King	27021		336.983.3878		Dr. Lori Coe/Joann
AEGIS FAMILY HEALTH CENTER DBA	2295 East 14th St, Suite 100	Winston-Salem	27105	Forsyth	336.725.0514	336.725.2173	Dr. Charlie Kenned
AHDIEH,MASOUD,	711 LONG DRIVE	ROCKINGHAM	28379	Richmond	910.997.7180	910.997.3830	Dr. Ahdieh
ASHEVILLE CHILDRENS MED CTR PA	53 S FRENCH BROAD AVE	ASHEVILLE	28801		828.258.0969	828.258.8403	Dr. William Bryan I
BECKFORD MEDICAL CTR PA	176 Beckford Drive	HENDERSON	27536		252.492.2161	252.438.2888	Dr. James Kenney
BHAGWANDASS,SHEILA,	915 PARK AVENUE	ROANOKE RAPIDS	27870	Halifax	252.537.6465		Dr. Bhagwandass
Boice Willis Cllinic	PO Box 720/901 N Winstead Ave	Rocky Mount	27804		252.937.0285		Dr. David Brantley
Boland,Pamela,G	125 Medical Park Lane, Suite H	Murphy	28906	Cherokee	828.837.2128	828.837.6244	Dr. Boland
Carolina Pediatrics	201 S Colony Avenue	Ahoskie	27910				
CHILDRENS CLINIC PA	1920 South 16th Street	WILMINGTON	28401	New Hanover	910.762.3942	910.763.1586	Dr. Jason Fields (815.3222X626 V.M
Cornerstone Med Ctr	1041 Kirkpatrick Rd, Ste 100	Burlington	27215	Alamance	336.538.0565	336.538.0564	Dr. Morissey/ Donna Odum (nurs
Duap-Durham Pediatrics	2609 N Duke Street, Suite 801	Durham	27704		919.220.4000		Dr. Gagliano Dr. Anita Blosser,
Duap-Henderson Family Medicine	511 Ruin Creek Road, Suite 101	Henderson	27536		252.492.3152	252.430.1928	Nora Humphries, C
DUAP-OXFORD FAMILY PHYSICIANS	101-A Profession Park	OXFORD	27565	Granville	919.693.3972	919.693.1750	Dr. Anderson
Faith Pediatrics	3350 SixForks Rd, Park PI Bldg	Raleigh	27609	Wake	919.881.9440	919.881.9465	Dr. Connell Coving
Rocky Mt/Nash Pediatrics	600 Nash Medical Arts Avenue	Rocky Mount	27804	Nash	252.451.3100	252.451.3141	Dr. Harold Bailey
HENDERSON PEDIATRIC CENTER	1924 Ruin Creek Road, Suite 101	HENDERSON	27536	Vance	252.492.9565	252.492.5373	Dr. Cathcart
Heritage Medical Associates	1905 Skibo Road	Fayetteville	28314				
Highland Pediatrics	3415 C Melrose Road	Fayetteville	28304	Cumberland	910.484.8163		Dr. Hall (Dr. McCut
John Gaston MD DBA	2312-B Murchinson Road	Fayetteville	28301				
Carteret Co Adol & Child Clinic	221 Professional Circle	Morehead City	28557	Cartaret New	252.726.0511	252.726.7441	Dr. John Knelson/L
KNOX CLINIC	2304 Delaney Avenue	WILMINGTON	28403	Hanover	910.763.3349	910.251.9428	Dr. Angelina Knox
LARRY C HARRIS MD PA	1271 Oliver Street	FAYETTEVILLE	28304	Cumberland	910.323.4281	910.323.2842	Dr. Harris

Larry T. Jones	2949 New Bern Avenue, Ste 112-A	Raleigh	27610	Wake	919.212.0620		Dr. Jones
Matthew Desena MD DBA	520 South Van Buren Road	Eden	27288		336.627.5437		
MELROSE PEDIATRIC CARE	3419-B Melrose Road	FAYETTEVILLE	28304	Cumberland	910.323.9905	910.609.5406	Dr. Clarito Pang/ Linda Frye (nurse)
MOUNTAIN AREA PEDIATRIC	500 CENTREPARK DRIVE	ASHEVILLE	28805		828.254.4337		Kerri Dalton, office
MULBERRY PEDIATRICS	P O BOX 3300	LENOIR	28645		828.757.5509	828.757.5538	Ben Bailey, MD
Nasiri,M A Sabur	508 Sandhurst Drive	Fayetteville	28304		910.485.0900	910.485.0080	Dr. Dravland
Pabst, Mark	805B Tilghman Drive	Dunn	28334			910.592.5797	Dr. Nasiri
Halifax Pediatrics	402 Becker Drive/PO Box 787	Roanoke Rapids	27870	Halifax	252.537.1400	252.537.4396	Jeannie Autry/Mar
Raleigh Peds	4905 Professional Court	Raleigh	27609		919.872.0250	919.662.2021	Dr. Paulette Ingran
ROBERSON,JILL,R	106 PHYSICIANS PARK DR	ROCKINGHAM	28379	Richmond	910.895.6070	910.895.4054	Dr. Jeff Johnson
Ronald May	1403 McCarthy Blvd	New Bern	28560		252.636.1919		Dr. Roberson
RUTHERFORD PEDIATRICS PA	141 Tryon Road, Suite A	RUTHERFORDT ON	28139	Rutherford	828.286.9049	828.286.5596	Dr. Ronald May
SALISBURY CHILDRENS CLINIC	720 Grove Street	SALISBURY	28144		704.636.5576	704.636.1755	Dr. Willis Archer
Schwankl, James & Assoc PA	806 W 4th Street	Siler City	27344	Chatham	919.742.2209	919.742.1310	Dr. Charles Magryt
SYLVA PEDIATRIC ASSOCIATES PA	186 Medical Park Loop, Ste 501	SYLVA	28779	Jackson	828.586.5594	828.586.3040	Dr. James Schwanl
VALLEY PEDIATRIC CARE	1213 Walter Reed Road	FAYETTEVILLE	28304	Cumberland	910.484.6121	910.484.6322	Sherrie Dills
Wake Co. Human Services	10 Sunbrook Road	Raleigh	27610	Wake	919.250.4579	919.212.9325	Dr. McCutcheon/ Dana Dorman (nur
Wake Medical Center	3000 New Bern Ave, Peds 4th Fl	Raleigh	27613	Wake	919.258.7337		Janeth Pearl, FNP
							Dr. Anne Yeakey

APPENDIX B2

Table-Practice Status during Collaborative

PRACTICE PARTICIPATION	N	NOTES
Practices meeting Parameters for Recruitment	42	Access 1 pediatric practice with high volume of asthmatics and Medicaid enrollees
Recruitment Phone Calls Made	42	Phone calls were made by Drs Carole Lannon, Peter Margolis, John Whalley, Joe Ponzi to lead physicians in these practices. Multiple follow up calls conducted by project manager.
Recruitment Packets Sent	42	All practices who expressed interest to Dr Lannon were sent packets describing the project timeline and activities with participation agreement to sign.
Participant Agreement	22	20 returned. Reasons given for declining participation included: short staffing, involvement in other asthma programs, too busy (please contact again), partner leaving, ineligible Access II.
Pework Sent	22	The prework begins the project for the practice with data collection instructions, and overview of gap in asthma care. Packet went to all physicians who made a verbal agreement.
Withdrawal during prework period prior to LS 1	5	DUAP Oxford (in another BTS, very busy) Highland /Valley (practice in transition with merge of 2 practices) Carteret County (physician not available for this work) Melrose (doing a lot in asthma already) Jill Roberson (medical leave)
Learning Session 1	17	One practice unable to attend but in collaborative (total 18 includes Tennessee practice)
Withdrawal during collaborative	4	These teams withdrew between LS1 (March 28, 2002) and LS3 (November 15,2002) Cornerstone (made some changes, data collection unsuccessful) Pam Boland (staff turnover) Children's Clinic—Dr Fields (not able to form team) Henderson (highest # of asthmatics, made site visit, no senior support and unable to form team) Sylva (nurse left)
Completed	13	13 practices participated for the majority of the Collaborative
		Note: Chatham, Sylva, Melrose withdrew and re-entered –numbers do not add up.

Living with Asthma -- Patient/Parent Survey – Page 1

This survey will help us take better care of you/your child and his/her asthma. **Please complete the first page before you go into the exam room, bring the survey with you and give it to your provider at the beginning of the visit. After you have seen your provider, please complete page 2 of this survey and return it before you leave.** If you need help, please ask a staff member.

Patient's Name _____ ID Code # _____

Practice Name _____ Date of Survey _____

1. The reason I am here today is for:

- ☐ A planned visit (for well-child care, asthma follow-up, or a review of how my child is doing)
- ☐ A “sick” visit for an asthma attack → If this is a “sick” visit please describe triggers _____ ☐ Unsure of triggers

For questions 2 and 3, check **one choice for each** that best describes your child's health **in the last two weeks.**

2. Coughing, wheezing, shortness of breath or tightness in the chest during the <u>day</u> ?	3. Coughing, wheezing, shortness of breath or tightness in the chest at <u>night</u> ?	<i>For clinician use only</i>
<input type="checkbox"/> All the time (never normal breathing)	<input type="checkbox"/> Frequently / Every night	QQQQ
<input type="checkbox"/> Every day	<input type="checkbox"/> More than once a week	QQQ
<input type="checkbox"/> Three to six times a week	<input type="checkbox"/> Once a week	QQ
<input type="checkbox"/> Twice a week or less	<input type="checkbox"/> Once every two weeks or less	Q

4. On how many of the past 14 days has your child had any wheezing during the day, awakening at night (due to cough, wheeze, or trouble breathing), or had to slow down or stop play because of these asthma symptoms?
_____ days
5. Has your child missed any school days or daycare because of asthma in the last two months?
☐ No ☐ Yes → If Yes, number of days missed: _____ ☐ Doesn't go to school or daycare
6. Has your child had any visits to this or any practice/clinic for an asthma attack in the last two months?

☐ No ☐ Yes → If Yes, approximate dates: _____

7. Has your child been to the ER or hospitalized due to asthma in the last six months?

ER visits: ☐ No ☐ Yes → If Yes, approximate dates: _____

Hospitalizations: ☐ No ☐ Yes → If Yes, approximate dates: _____

8. How often is your child exposed to cigarette smoke?

☐ Every day ☐ Once or twice a week ☐ Rarely ☐ Never

The following questions are about quick relief medicine (Albuterol, Proventil, Ventolin, Maxair, Tornalate, Xopenex)

9. Does your child take a quick relief medicine for asthma ☐ No → (if No, go to question #12) ☐ Yes

10. When does your child take quick relief medicine? *(please check all that apply)*

☐ For symptoms (cough or wheeze) ☐ For exercise ☐ Pretty much every day with or without symptoms

11. In the last two weeks, how many times did your child take quick relief medicine to help relieve coughing, wheezing, shortness of breath or tightness in the chest? ☐ More than twice a week ☐ Twice a week or less

Please give this page of the survey to your provider at the beginning of the visit

Living with Asthma -- Patient/Parent Survey – Page 2

Please complete this page of the survey after you have seen the doctor or nurse practitioner.

The following questions are about controller or preventive medicines that some kids with asthma are supposed to take every day, even when they are feeling fine. If you have been using one or more of these medicines and will continue to take it, or if your doctor or nurse just told you to start taking any of these medicines, please answer yes below. Please check one answer for each question.

Patient's Name _____ ID Code # _____

Practice Name _____ Date of Survey _____

12. Is your child supposed to take Cromolyn (also called Intal) or Nedocromil (also called Tilade)?

☐ No ☐ Yes ☐ Not sure

13. Is your child supposed to take any inhaled type of steroid medicine for his/her asthma (Vanceril, Beclovent, Azmacort, Aerobid, Flovent, or Pulmicort)?

☐ No ☐ Yes ☐ Not sure

14. Is your child supposed to take Accolate or Singulair (a daily pill) for his/her asthma?

☐ No ☐ Yes ☐ Not sure

The following questions are about a written asthma management plan. This is a set of instructions about how to treat your child's asthma, with different treatments depending on how your child's asthma is doing. It is used for patients who take medicine every day.

15. Did your doctor or nurse review with you a written asthma management plan for your child's asthma **today**?

- ☐ No
- ☐ Yes, today we reviewed a new plan
- ☐ Yes, today we reviewed a plan written at an earlier visit
- ☐ Not sure

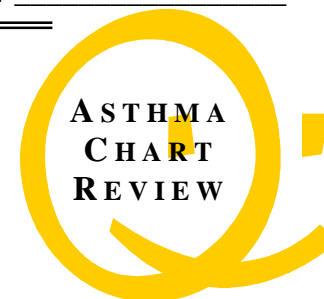
16. Do you currently have a written copy of your child's asthma management plan?

- ☐ No
- ☐ Yes
- ☐ Not sure

***Please return the survey to the front desk or give it to the nurse.
Thank you very much for completing this survey!***

Practice _____ Date of Visit: ____/____/____ Reviewer's Initials: ____

Date of Review: ____/____/____ Patient's Date of Birth ____/____/____ ID Code # _____



1. Type of Visit:

- ☐ Acute Visit for asthma/respiratory symptoms
- ☐ Asthma Follow Up (after acute clinic visit, ER or urgent care visit, hospitalization for asthma)
- ☐ Asthma Maintenance visit
- ☐ Well Child Visit

2. Is Asthma Severity Classification noted in the chart for this visit (Mild Intermittent, Mild Persistent, Moderate Persistent or Severe Persistent)?

- ☐ No
- ☐ Yes → **If Yes**, what is the classification of severity?
 - ☐ Mild Intermittent
 - ☐ Mild Persistent
 - ☐ Moderate Persistent
 - ☐ Severe Persistent

3. Please check all anti-inflammatory medications prescribed at this visit or at the previous visit and ordered to be continued.

- ☐ Cromolyn sodium (Intal)
- ☐ Nedocromil sodium (Tilade)
- ☐ Montelukast (Singulair)
- ☐ Zafirlukast (Accolate)
- ☐ Beclomethasone dipropionate (Beclovent, Vanceril, Vanceril-DS)
- ☐ Budesonide (Pulmicort Turbohaler or Respules)
- ☐ Flunisolide (AeroBid, Aerobid-M)
- ☐ Fluticasone propionate (Flovent)
- ☐ Triamcinolone (Azmacort)

4. Is the patient prescribed a beta₂-agonist (e.g. albuterol - Proventil, Ventolin; pirbuterol - Maxair; bitolterol - Tornalate; levabuterol - Xopenex) for quick relief?

- ☐ No / Not documented
- ☐ Yes → **If Yes**, please indicate frequency: → **and**, please indicate route:
 - ☐ PRN (as needed)
 - ☐ Daily
 - ☐ Both
 - ☐ Not documented
 - ☐ Inhaled (MDI or nebulizer)
 - ☐ Oral (syrup)
 - ☐ Both
 - ☐ Not documented

An Asthma Management Plan is a written handout for the patient describing when and how to take medications.

5. At this visit, was a written Asthma Management Plan created or an existing plan updated or reviewed?

- | | |
|---|---|
| <input type="checkbox"/> A NEW plan was created
→ | Was the family given a <u>WRITTEN COPY</u> of the Asthma Management plan at this visit? <input type="checkbox"/> No / Not Documented <input type="checkbox"/> Yes |
| <input type="checkbox"/> An existing Plan was revised/updated
→ | Was the family given a <u>WRITTEN COPY</u> of the Asthma Management plan at this visit? <input type="checkbox"/> No / Not Documented <input type="checkbox"/> Yes |
| <input type="checkbox"/> An existing Plan was reviewed
→ | Was the family given a <u>WRITTEN COPY</u> of the Asthma Management plan at this visit? <input type="checkbox"/> No changes made, no new copy needed |
| <input type="checkbox"/> No written Asthma Management Plan was created/An existing plan was not updated or reviewed | |

Assessment of Chronic Illness Care

Version 3

Please complete the following information about you and your organization. This information will not be disclosed to anyone besides the ICIC/IHI team. We would like to get your phone number and e-mail address in the event that we need to contact you/your team in the future. Please also indicate the names of persons (e.g., team members) who complete the survey with you. Later on in the survey, you will be asked to describe the process by which you complete the survey.

Your name:	Date: _____/_____/_____ Month Day Year
Organization & Address:	Names of other persons completing the survey with you:
	1.
	2.
	3.
Your phone number: (____) ____ - ____ ____	Your e-mail address:

Directions for Completing the Survey

This survey is designed to help systems and provider practices move toward the "state-of-the-art" in managing chronic illness. The results can be used to help your team identify areas for improvement. Instructions are as follows:

1. **Answer each question** from the perspective of one physical site (e.g., a practice, clinic, hospital, health plan) that supports care for chronic illness.

Please provide name and type of site (e.g., Group Health Cooperative/Plan)

2. **Answer each question** regarding how your organization is doing with respect to one disease or condition.

Please specify condition _____

3. For each row, **circle the point value** that best describes the level of care that currently exists in the site and condition you chose. The rows in this form present key aspects of chronic illness care. Each aspect is divided into levels showing various stages in improving chronic illness care. The stages are represented by points that range from 0 to 11. The higher point values indicate that the actions described in that box are more fully implemented.

4. **Sum the points in each section** (e.g., total part 1 score), calculate the average score (e.g., total part 1 score / # of questions), and enter these scores in the space provided at the end of each section. Then sum all of the section scores and complete the average score for the program as a whole by dividing this by 6.

For more information about how to complete the survey, please contact:

Amy E. Bonomi, MPH
bonomi.a@ghc.org

tel. 206.287.2238;

Improving Chronic Illness Care
A National Program of the Robert Wood Johnson Foundation
Group Health Cooperative of Puget Sound
1730 Minor Avenue, Suite 1290
Seattle, WA 98101-1448

SITE NAME: _____

Goals and Actions:

1. *Prescribing appropriate medications for asthma severity with a goal of 95% of patients with persistent asthma will be on anti-inflammatory medications*
2. *Completing and distributing asthma management plans with a goal of 90% of patients with persistent asthma will have a written asthma management plan at home and in the medical record*
3. *Reducing the number of days with symptoms for all asthma patients with a goal of an average of 10 symptom free days in the last 2 weeks*
4. *Beginning to develop an asthma registry with the goal of adding at least 10 new patients each week*
- 5.
- 6.

Goal #	Changes tested / Implemented	Results/ Comments -- What did you learn from this test?

Progress / Results summary:

patients in registry: _____

Other:

To complete the Monthly Progress Report:

1. Fill in your site name
2. Fill out the Goals section of the report, including ALL the goals and activities you're currently working on.
3. Fill in the table by listing the changes you're trying (column 2), which goal (listed in the Goals section) it's related to (column 1), and what you learned from that test (column 3).
4. Briefly summarize your progress in general in the summary section.
5. Provide any additional data and/ or graphs relevant to your individual aims, goals and measures.
6. Fax or email it to Shawn Hatcher, EQUIS Project Coordinator, by the 10th of the following month. (email: shatcher@ihi.org; fax: 617-754-4848)

Office of Public Health Nursing and Professional Development

ED I Participant Feedback Tool

Name Of Activity: **NC DMA Asthma Learning Collaborative - Learning Session One**

Date: **March 28, 2001**

Location: **Sheraton Chapel Hill**

Activity #: **AP-32-**

Purpose/Goals: This program will enable healthcare professionals to maximize the length and quality of life for patients with asthma and their families by implementing a system-wide model of care that focuses on assuring the delivery of evidence-based clinical care and strong support for patient and family self-management.

I. Please rate the effectiveness of this continuing education activity in meeting its objectives.

Objective		Excellent	Good	Fair	Poor
<u>Defining the Gap:</u> 1. Identify gaps in the current state of asthma care in the US	<u>Objective achieved</u> <u>Relation to purpose/goals</u> <u>Appropriateness of teaching strategies</u>	 	 	 	
<u>Baseline Assessment and Feedback:</u> 1. Analyze their team's baseline data (or sample data) 2. Identify opportunities for improvement	<u>Objective achieved</u> <u>Relation to purpose/goals</u> <u>Appropriateness of teaching strategies</u>	 	 	 	

<u>Improving Chronic Illness Model:</u> 1. Identify components of the ICIC Model 2. Formulate examples of the components using a case study	<u>Objective achieved</u> <u>Relation to purpose/goals</u> <u>Appropriateness of teaching strategies</u>	_____	_____	_____	_____
<u>Core Components of Asthma Care:</u> 1. Describe essential components for best asthma care, in the context of the ICIC Model	<u>Objective achieved</u> <u>Relation to purpose/goals</u> <u>Appropriateness of teaching strategies</u>	_____	_____	_____	_____
<u>Models for Improvement:</u> 1. Identify the components of the model for Improvement and the PDSA cycle 2. Practice process improvement strategies	<u>Objective achieved</u> <u>Relation to purpose/goals</u> <u>Appropriateness of teaching strategies</u>	_____	_____	_____	_____
<u>Self-Management Support:</u> 1. Define key components of self-management 2. Compose a self-management strategy using an action plan	<u>Objective achieved</u> <u>Relation to purpose/goals</u> <u>Appropriateness of teaching strategies</u>	_____	_____	_____	_____

<u>Measurement for Quality Improvement:</u> 1. Apply ongoing data collection process 2. Employ measurement to identify additional areas for improvement in asthma care	<u>Objective achieved</u>	_____	_____	_____	_____
	<u>Relation to purpose/goals</u>	_____	_____	_____	_____
	<u>Appropriateness of teaching strategies</u>	_____	_____	_____	_____

ED I Participant Feedback Tool

Objective		Excellent	Good	Fair	Poor
<u>Clinical Information Systems Using a Registry:</u> 1. Demonstrate how to use a registry to provide care in the planned care, population based model (ICIC) 2. Formulate a plan to implement a registry system at your site	<u>Objective achieved</u>	_____	_____	_____	_____
	<u>Relation to purpose/goals</u>	_____	_____	_____	_____
	<u>Appropriateness of teaching strategies</u>	_____	_____	_____	_____
<u>Delivery System Design:</u> 1. Recognize your clinical site as a system 2. Apply a system approach at	<u>Objective achieved</u>	_____	_____	_____	_____
	<u>Relation to purpose/goals</u>	_____	_____	_____	_____
	<u>Appropriateness of teaching strategies</u>	_____	_____	_____	_____

your site					
<u>Team Huddle:</u> 1. Discuss strategies for implementing best practice asthma management 2. Develop a detailed plan for first cycles of change	<u>Objective achieved</u> <u>Relation to purpose/goals</u> <u>Appropriateness of teaching strategies</u>	_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____
<u>Wrap Up and Next Steps:</u> 1. Identify resources for action period one 2. Integrate ongoing data collection for QI	<u>Objective achieved</u> <u>Relation to purpose/goals</u> <u>Appropriateness of teaching strategies</u>	_____ _____ _____	_____ _____ _____	_____ _____ _____	_____ _____ _____

II. Please rate the audiovisuals/handouts used for this workshop.

Excellent		Good		Fair		Poor	
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III. Please evaluate the physical environment where the workshop was held:

Excellent		Good		Fair		Poor	
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IV. Please evaluate the overall program:

Excellent		Good		Fair		Poor	
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ED I Participant Feedback Tool

V. Please evaluate the expertise of each faculty member individually:

Faculty	<u>Excellent</u>	<u>Good</u>	<u>Fair</u>	<u>Poor</u>
Charlie Homer, MD, MPH				
Lloyd Provost, MD				
Dan Hyman, MD				
Jayne Stuart, MPH				
Divvie Powell, RN, MSN				

VI. How do you plan to use this information in your practice setting?

VII. General comments and/or suggestions:

VIII. Do you have suggestions for future educational programs?

Thank you for completing this course evaluation. Your opinion is very important to us!

Participant Feedback Tool

Name Of Activity: NC-DMA Asthma Learning Collaborative –Learning Session Two

Date: June 6, 2001 **Location:** Sheraton Chapel Hill **Activity #:** _____

Purpose/Goals: This program will enable healthcare professionals to maximize the length and quality of life for patients with asthma and their families by implementing a system-wide model of care that focuses on assuring the delivery of evidence-based clinical care and strong support for patient and family self management.

I. Please rate the effectiveness of this continuing education activity in meeting its objectives.

Objective		Excellent	Good	Fair	Poor
<u>Introduction and Welcome/Review of progress to date. Examples of Successful Changes:</u> 1. Review team's progress to date in closing the gap between baseline and best practice. 2. Discuss key strategies employed by presenting teams. 3. Identify at least two approaches to accelerating improvement.	<u>Objective achieved</u>	_____	_____	_____	_____
	<u>Relation to purpose/goals</u>	_____	_____	_____	_____
	<u>Appropriateness of teaching strategies</u>	_____	_____	_____	_____

<u>Self Management Support:</u> 1. Define key components of self management. 2. Design a self management strategy using an action plan.	<u>Objective achieved</u> <u>Relation to purpose/goals</u> <u>Appropriateness of teaching strategies</u>	_____	_____	_____	_____
<i>Spreading Change</i> 1. Identify key dimensions for successful spread of improvements to the rest of the practice or organization.	<u>Objective achieved</u> <u>Relation to purpose/goals</u> <u>Appropriateness of teaching strategies</u>	_____	_____	_____	_____
<u>Team Sharing of Changes:</u> 1. Identify and share specific improvements in chronic care (decision support, system design, information mgmt, community resources and self management) tested in their organizations	<u>Objective achieved</u> <u>Relation to purpose/goals</u> <u>Appropriateness of teaching strategies</u>	_____	_____	_____	_____
What Happens When They Don't Get Better: 1. Identify three strategies for building a system to identify and ameliorate treatment failures.	<u>Objective achieved</u> <u>Relation to purpose/goals</u> <u>Appropriateness of teaching strategies</u>	_____	_____	_____	_____
<u>Decision Support-Clinical Update:</u> 1. Demonstrate use of a variety of medication devices for asthma care. 2. Identify appropriate devices based on patient needs/preferences.	<u>Objective achieved</u> <u>Relation to purpose/goals</u> <u>Appropriateness of teaching strategies</u>	_____	_____	_____	_____

3. Develop individualized asthma plan to improve patient's ability to manage own illness.					
<p>Community Resources:</p> <ol style="list-style-type: none"> 1. Identify community partners. 2. Identify key activities that would be beneficial for PCP's and community partners. 3. Identify strategies for prioritizing partnerships. 4. Discuss strategies to help PCP's identify and meet the needs of partners. 	<p><u>Objective achieved</u></p> <p><u>Relation to purpose/goals</u></p> <p><u>Appropriateness of teaching strategies</u></p>	<p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p>
<p>Smoking Cessation:</p> <ol style="list-style-type: none"> 1. Describe latest pharmacology in smoking cessation therapeutics. 2. Apply self management strategies to adolescent population. 	<p><u>Objective achieved</u></p> <p><u>Relation to purpose/goals</u></p> <p><u>Appropriateness of teaching strategies</u></p>	<p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p>
<p>Team Huddle:</p> <ol style="list-style-type: none"> 1. Develop plans for test and implementation cycles for a focused population during second action period. 2. Complete planning forms to assist individual team work upon return from the learning session. 3. Identify plans for spread to other populations or sites. 	<p><u>Objective achieved</u></p> <p><u>Relation to purpose/goals</u></p> <p><u>Appropriateness of teaching strategies</u></p>	<p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p>

<u>Next Steps:</u> 1. Restate the role of the Collaborative in progress during next action period. 2. Develop a plan for sustaining momentum in the next months.	<u>Objective achieved</u>				
	<u>Relation to purpose/goals</u>				
	<u>Appropriateness of teaching strategies</u>				

ED I Participant Feedback Tool

II. Please rate the audiovisuals/handouts used for this workshop.

Excellent		Good		Fair		Poor	
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III. Please evaluate the physical environment where the workshop was held:

Excellent		Good		Fair		Poor	
-----------	--	------	--	------	--	------	--

IV. Please evaluate the overall program:

Excellent		Good		Fair		Poor	
-----------	--	------	--	------	--	------	--

V. Please evaluate the expertise of each faculty member individually:

Faculty	<u>Excellent</u>	<u>Good</u>	<u>Fair</u>	<u>Poor</u>
Charlie Homer, MD, MPH				
Dan Hyman, MD				
Divvie Powell, RN, MSN				
Carole M. Lannon, MD, MPH				
Sam Weir, MD				
Betsy La Forge, MPH, RD				
Rita Heath, RT				
Janice Anderson, RN, MSN				
Casey Herget, MSW, MPH				
Debbie Cruse, LPN				

VI. How do you plan to use this information in your practice setting?

ED I Participant Feedback Tool

VII. General comments and/or suggestions:

VIII. Do you have suggestions for future educational programs?

Thank you for completing this course evaluation. Your opinion is very important to us.

Participant Feedback Tool

Name Of Activity: NC-DMA Asthma Learning Collaborative Learning Session III

Date: 11/15/01

Location: Holiday Inn-Raleigh Durham Airport

Purpose/Goals: This program will enable healthcare professionals to maximize the length and quality of life for patients with asthma and their families by implementing a system-wide model of care that focuses on assuring the delivery of evidence-based clinical care and strong support for patient and family self-management.

I. Please rate the effectiveness of this continuing education activity in meeting its objectives.

Objective		Excellent	Good	Fair	Poor
Introduction and Bureau Video 1. Discuss care model, collaborative model and the model for improvement through the eyes of a patient.	<u>Objective achieved</u> <u>Relation to purpose/goals</u> <u>Appropriateness of teaching strategies</u>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
<u>Team Sharing</u> 1. Identify key approaches to accelerating clinical quality improvement. 2. Identify strategies for collaboration with other practice teams. 3. Incorporate “best practice” models from other teams into improvement strategies.	<u>Objective achieved</u> <u>Relation to purpose/goals</u> <u>Appropriateness of teaching strategies</u>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>

<u>Culture and Clinical Care: An Approach to Folk Illness Beliefs and Practices</u> 1. Identify cultural beliefs in an individual's approach to health, illness and healthcare. 2. Identify cultural beliefs and practices pertaining to childhood illnesses, particularly asthma. 3. Incorporate cultural and personal health beliefs and practices into patient care and education.	<u>Objective achieved</u> <u>Relation to purpose/goals</u> <u>Appropriateness of teaching strategies</u>	_____	_____	_____	_____
<u>Next Steps</u> 1. Plan how best to apply of key concepts of LS3 during Action Period 3.	<u>Objective achieved</u> <u>Relation to purpose/goals</u> <u>Appropriateness of teaching strategies</u>	_____	_____	_____	_____
<u>Delivery System Design Part II</u> 1. Evaluate practice's successes to date in the redesign of delivery of care (using a system approach) to improve quality of care given to children with asthma 2. Identify how further system based redesign in the office/health center setting can improve care for children with asthma.	<u>Objective achieved</u> <u>Relation to purpose/goals</u> <u>Appropriateness of teaching strategies</u>	_____	_____	_____	_____

<u>Progress to Date</u> 1.Use data to identify gaps and opportunities for clinical quality improvement during Action Period 3.	<u>Objective achieved</u> <u>Relation to purpose/goals</u> <u>Appropriateness of teaching strategies</u>	_____	_____	_____	_____
<u>Team Huddle</u> 1.Develop plans to test and implement cycles in a target population during Action Period 3. 2.Utilize planning and implementation forms to assist teamwork upon returning to practice from LS3. 3.Evaluate opportunities to share information with colleagues and spread learnings to rest of practice.	<u>Objective achieved</u> <u>Relation to purpose/goals</u> <u>Appropriateness of teaching strategies</u>	_____	_____	_____	_____
<u>As Easy as ABC? Asthma Management in the School Setting</u> 1.Identify common objectives of health care teams and school nurses. 2.List three ways practices can partner with schools to improve care. 3.Describe how practices and schools can collaborate to provide care for children with asthma.	<u>Objective achieved</u> <u>Relation to purpose/goals</u> <u>Appropriateness of teaching strategies</u>	_____	_____	_____	_____

<u>Managing Chronic Illness- Building the Case for Quality in the Pediatric Office</u> 1.Code and document office and hospital_services provided to patients with asthma. 2.Use office coding tools including coding prompts and office encounter forms to provide efficiency in documentation. 3.Relate coding skills to other providers in individual practices..	<u>Objective achieved</u>	_____	_____	_____	_____
	<u>Relation to purpose/goals</u>	_____	_____	_____	_____
	<u>Appropriateness of teaching strategies</u>	_____	_____	_____	_____

II. Please rate the audiovisuals/handouts used for this workshop.

Excellent		Good		Fair		Poor	
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III. Please evaluate the physical environment where the workshop was held:

Excellent		Good		Fair		Poor	
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IV. Please evaluate the overall program:

Excellent		Good		Fair		Poor	
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Participant Feedback Tool

V. Please evaluate the expertise of each faculty member individually:

Faculty	<u>Excellent</u>	<u>Good</u>	<u>Fair</u>	<u>Poor</u>
Dan Hyman, MD				
Carole Lannon, MD				
Divvie Powell, RN, MSN				
Lee Pachter, MD				
Janice Anderson, RN, MSN				
Joel Bradley, MD				

VI. How do you plan to use this information in your practice setting?

VII. General comments and/or suggestions:

VIII. Do you have suggestions for future educational programs?

Thank you for completing this course evaluation. Your opinion is very important to us!

NC-DMA Asthma Learning Collaborative

Collaborative Evaluation

The Children's Primary Care Research Group/NICHO values your feedback. Please complete the following questions so that we may improve upon the Asthma Learning Collaborative and future Collaboratives.

This evaluation will take approximately 7-10 minutes to complete.

I. When recruited for the Collaborative, were the expectations for your team's participation in the Collaborative clear and accurate? (CIRCLE ONE)

1	2	3	4	5
Not at all			Very much so	

COMMENTS: _____

II. Were the Prewrite packet and storyboard instructions sent out prior to LS1 useful in your team's preparation for the Collaborative and Learning Sessions? (CIRCLE ONE)

1	2	3	4	5
Not at all			Very much so	

How can we improve the Prewrite? _____

III. Was the recommended team composition for this Collaborative a good fit for your organization's work in the Collaborative? (CIRCLE ONE)

1	2	3	4	5
Not at all			Very much so	

COMMENTS: _____

IV. Is the structure and process of the Learning Sessions beneficial to your team's learning? (CIRCLE ONE)

1	2	3	4	5
Not at all			Very much so	

How can we improve upon the structure and process of the Learning Sessions?

LS1_____

LS2_____

LS3_____

V. Is the content of the Learning Sessions useful in your team's improvement work? (CIRCLE ONE)

1	2	3	4	5
Not at all			Very much so	

How can we improve upon the content of the Learning Sessions?

LS1_____

LS2_____

LS3_____

VI. How would you rate the level of support provided to your team during Action Periods. (CIRCLE ONE)

1	2	3	4	5
Poor			Excellent	

COMMENTS: _____

VII. How would you rate your team's overall experience in the Collaborative? (CIRCLE ONE)

1	2	3	4	5
Poor			Excellent	

VIII. Please provide us with any additional comments or suggestions to assist us in improving the Asthma Learning Collaborative or future Collaboratives.



NC-DMA ALC
Conference Call Survey

The NICHQ team is constantly working to improve our projects. Please take a few minutes to answer the following questions about the NC-DMA ALC conference calls. Your responses will be used to help us evaluate the content and approach we have used for team calls.

1. What was your goal for participating in the conference call(s)?

2. Approximately how many NC-DMA ALC conference calls have you attended?

0

1 – 3

4 – 6

7 or more

3. Did you achieve your goal? Yes No

Please explain. _____

4. If you did not attend the conference calls, please tell us a little about why you did not.

5. Please list the 2 things you found most helpful about the calls.

6. Please list 2 things that could be changed that would result in the calls being more useful for your team.

7. Please tell us which topics you liked.

8. Please list a few topics you would like future conference calls to cover.

THANK YOU!

Practice Name	Pework Data	LS1	LS2	LS3	Conf Calls	Final Conf Call	Prog Rpts	Data ChR/Sur [140/140]	Registry
ABC Pediatrics	yes	2	0	0	2/13	no	0/10	72/81	no
Aegis Family Health Center	yes	3	0	1	2/13	no	0/10	44/43	yes
Chatham Pediatrics	n/a	2	1	0	7/13	no	0/10	20/12	yes
Children's Clinic PA	no	1	0	0	1/13	no	0/10	6/5	no
Cornerstone Medical Center	yes	3	1	0	2/13	no	0/10	10/10	no
Faith Pediatrics	yes	1	1	1	3/13	no	2/10	34/26	no
Halifax Pediatrics	yes	4	2	1	1/13	no	8/10	40/80	yes
Henderson Pediatric Center	no	1	1	0	0/13	no	0/10	0/0	no
Knox Clinic Pediatrics	yes	4	0	0	5/13	no	2/10	37/38	yes
Larry C. Harris, MD, PA	yes	1	1	1	11/13	yes	1/10	77/76	yes
Masoud Ahdieh, MD, PA	yes	1	1	0	2/13	no	0/10	18/18	no
Melrose Pediatric Care	n/a	n/a	2	0	0/13	no	0/10	0/0	no

Park Avenue Pediatrics	yes	3	1	0	3/13	no	5/10	66/64	paper
Premier Medical Group	no	2	1	1	3/13	no	0/10	23/0	no
Rocky Mount-Nash Pediatrics	yes	2	2	0	8/13	no	5/10	66/67	yes
Sylva Pediatrics	n/a	1	0	0	2/13	no	0/10	0/0	no
Wake Co. Human Services	yes	1	1	2	4/13	no	0/10	11/15	paper

Category I: Non-Participating Practices

➤ Children's Clinic PA	Wilmington, NC	Jason Fields, MD	910.762.3942
➤ Henderson Pediatrics	Henderson, NC	Ricky Mitchell, MD	252.492.9565
		Neal Cathcart, MD	
➤ Melrose Pediatrics	Fayetteville, NC	Clarito Pang, MD	910.609.4801
		Linda Frye, LPN	

GOAL: 1. Advise, based on previous history, suggest no longer participating.
2. Glean data to learn from this experience.

- We have missed you on our calls/learning sessions.
- Based on the response we have received thus far, we assume you will no longer be participating in the Collaborative. Is this a correct assumption?
- In interests of learning can you tell me:
 - How could the Collaborative have worked better for you?
 - Did you understand at the outset what the work of the Collaborative would entail?
 - Were there particular barriers or lack of resources that prohibited your practice's full participation?
 - Was the practice leadership supportive of your participation? Did you have practice leadership support?
 - Was a team (MD, RN and/or office person) identified?
 - Did you have Internet access?
 - How could the Collaborative have worked better for you? (would ask this second time as well)
 - If the DMA were to sponsor another collaborative what suggestions would you have?
 - Would you participate again?
 - Any other information that you would like to share that can assist our learning?

PRACTICE NAME: **CHILDREN'S CLINIC, PA**
CONTACT: _____

1. How could the Collaborative have worked better for you?
2. Did you understand at the outset what the work of the Collaborative would entail?
3. Were there particular barriers or lack of resources that prohibited your practice's full participation?
4. Was the practice leadership supportive of your participation? Did you have practice leadership support?
5. Was a team (MD, RN and/or office person) identified?
6. Did you have Internet access?
7. How could the Collaborative have worked better for you? (would ask this second time as well)
8. If the DMA were to sponsor another collaborative what suggestions would you have?

9. Would you participate again?
10. Any other information that you would like to share that can assist our learning?

PRACTICE NAME: **HENDERSON PEDIATRICS**

CONTACT: _____

1. How could the Collaborative have worked better for you?
2. Did you understand at the outset what the work of the Collaborative would entail?
3. Were there particular barriers or lack of resources that prohibited your practice's full participation?
4. Was the practice leadership supportive of your participation? Did you have practice leadership support?
5. Was a team (MD, RN and/or office person) identified?
6. Did you have Internet access?
7. How could the Collaborative have worked better for you? (would ask this second time as well)
8. If the DMA were to sponsor another collaborative what suggestions would you have?
9. Would you participate again?

10. Any other information that you would like to share that can assist our learning?

PRACTICE NAME: **MELROSE PEDIATRICS**

CONTACT: _____

1. How could the Collaborative have worked better for you?

2. Did you understand at the outset what the work of the Collaborative would entail?

3. Were there particular barriers or lack of resources that prohibited your practice's full participation?

4. Was the practice leadership supportive of your participation? Did you have practice leadership support?

5. Was a team (MD, RN and/or office person) identified?

6. Did you have Internet access?

7. How could the Collaborative have worked better for you? (would ask this second time as well)

8. If the DMA were to sponsor another collaborative what suggestions would you have?

9. Would you participate again?

10. Any other information that you would like to share that can assist our learning?

Category II: Practices Requiring Additional Support

➤ Masoud Ahdieh, MD, PA	Rockingham, NC	Charlotte McNeill, FNP	910.997.7180
➤ Cornerstone Pediatrics	Burlington, NC	Donna Odem, FNP	336.538.0565
➤ Knox Clinic Pediatrics	Wilimington, NC	Angelina Knox, MD	910.763.3349

GOAL: Facilitate/motivate towards progression – asthma season coming up, use of registry to bring in patients for flu shots, opportunity to establish management plan and educate, there are five months left in the Collaborative – plenty of time to see excellent results.

- Individualize discussion based on feedback reports.
- Pat on the back for progress and participation thus far.
- We want to ensure your practice's success and would like to offer any assistance we can to get you there.
- Example: "We see that you initially submitted 35 asthma surveys and chart reviews then did not submit any since. Can you help me to understand why?" (Offer recommendations based on area of struggle.)
- Does the practice leadership support your participation? Do you have practice leadership support?
- Are there barriers that we can assist with?
- Are there any suggestions that would make the Collaborative work better for your practice?

- Any other information that you think would be helpful?

PRACTICE NAME: **MASOUD AHDIEH, MD, PA**
 CONTACT: _____

1. Individualize discussion based on feedback reports.
2. Pat on the back for progress and participation thus far.
3. We want to ensure your practice's success and would like to offer any assistance we can to get you there.
4. Example: "We see that you initially submitted 35 asthma surveys and chart reviews then did not submit any since. Can you help me to understand why?" (Offer recommendations based on area of struggle)
5. Does the practice leadership support your participation? Do you have practice leadership support?
6. Are there barriers that we can assist with?
7. Are there any suggestions that would make the Collaborative work better for your practice?
8. Any other information that you think would be helpful?

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PRACTICE NAME: **CORNERSTONE PEDIATRICS**

CONTACT: _____

1. Individualize discussion based on feedback reports.
2. Pat on the back for progress and participation thus far.
3. We want to ensure your practice's success and would like to offer any assistance we can to get you there.
4. Example: "We see that you initially submitted 35 asthma surveys and chart reviews then did not submit any since. Can you help me to understand why?" (Offer recommendations based on area of struggle)
5. Does the practice leadership support your participation? Do you have practice leadership support?
6. Are there barriers that we can assist with?
7. Are there any suggestions that would make the Collaborative work better for your practice?
8. Any other information that you think would be helpful?

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PRACTICE NAME: **KNOX CLINIC PEDIATRICS**

CONTACT: _____

1. Individualize discussion based on feedback reports.
2. Pat on the back for progress and participation thus far.
3. We want to ensure your practice's success and would like to offer any assistance we can to get you there.
4. Example: "We see that you initially submitted 35 asthma surveys and chart reviews then did not submit any since. Can you help me to understand why?" (Offer recommendations based on area of struggle)
5. Does the practice leadership support your participation? Do you have practice leadership support?
6. Are there barriers that we can assist with?
7. Are there any suggestions that would make the Collaborative work better for your practice?

8. Any other information that you think would be helpful?

Category III: Good Performers

➤ Park Avenue Pediatrics	Roanoke Rapids, NC	Sheila Bhagwandass, MD	252.537.6465
➤ ABC Pediatrics	Dunn, NC	Brenda Surles, MD	910.892.1333
➤ Aegis Family Medical Ctr	Winston Salem, NC	Charlie Kennedy, MD	336.725.0514
➤ Faith Pediatrics	Raleigh, NC	Stephanie Patterson	919.881.9440

GOAL: 1. Pat on back.
2. Motivate to participate in areas that they have not previously during time remaining.

- Congratulations you have done a great job submitting data, monthly reports, bi-weekly conference calls, etc. What has enabled you to do this so well?
- Example: "I see that you dropped off submitting data/participating on bi-weekly calls? Can you tell me the reason for this and if we can do anything to facilitate your continued involvement?"
- We want to ensure your success. Is there anything we can do to improve your experience?
- Any other information you think would be helpful?

PRACTICE NAME: **PARK AVENUE PEDIATRICS**

CONTACT: _____

1. Congratulations you have done a great job submitting data, monthly reports, bi-weekly conference calls, etc. What has enabled you to do this so well?

2. Example: "I see that you dropped off submitting data/participating on bi-weekly calls? Can you tell me the reason for this and if we can do anything to facilitate your continued involvement?"

3. We want to ensure your success. Is there anything we can do to improve your experience?

4. Any other information you think would be helpful?

PRACTICE NAME: **ABC PEDIATRICS**
CONTACT: _____

1. Congratulations you have done a great job submitting data, monthly reports, bi-weekly conference calls, etc. What has enabled you to do this so well?

2. Example: "I see that you dropped off submitting data/participating on bi-weekly calls? Can you tell me the reason for this and if we can do anything to facilitate your continued involvement?"

3. We want to ensure your success. Is there anything we can do to improve your experience?

4. Any other information you think would be helpful?

PRACTICE NAME: **AEGIS FAMILY HEALTH CENTER**

CONTACT: _____

1. Congratulations you have done a great job submitting data, monthly reports, bi-weekly conference calls, etc. What has enabled you to do this so well?

2. Example: "I see that you dropped off submitting data/participating on bi-weekly calls? Can you tell me the reason for this and if we can do anything to facilitate your continued involvement?"

3. We want to ensure your success. Is there anything we can do to improve your experience?

4. Any other information you think would be helpful?

PRACTICE NAME: **FAITH PEDIATRICS**

CONTACT: _____

1. Congratulations you have done a great job submitting data, monthly reports, bi-weekly conference calls, etc. What has enabled you to do this so well?

2. Example: "I see that you dropped off submitting data/participating on bi-weekly calls? Can you tell me the reason for this and if we can do anything to facilitate your continued involvement?"

3. We want to ensure your success. Is there anything we can do to improve your experience?

4. Any other information you think would be helpful?

